The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Mental Health Counseling Form 4B
Certification of Supervised Experience

Applicant Instructions | Assigned Number (from Form 4): _____

1. Complete Section I. Be sure to sign and date item 9.
2. Send the entire form and a copy of Appendix A to the supervisor who will certify your experience to complete Section II and forward all pages of this form directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant.**

Section I: Applicant Information

1. Last 4 Digits of Social Security Number ☐☐☐☐ 2. Birth Date Month ☐☐ Day ☐☐ Year ☐☐☐☐
(Leave this blank if you do not have a U.S. Social Security Number)

3. Print Name
Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
First ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Middle ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Licensee business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.

4. Mailing Address ☐ Home or ☐ Business
(You must notify the Department within 30 days of any address or name changes)

Line 1 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Line 2 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Line 3 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
State ☐☐ ZIP Code ☐☐☐☐☐ ☐☐☐☐
Country/ Province ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

5. Telephone/Email Address
Daytime Phone
☐ Home or ☐ Business
☐☐☐ ☐☐☐ ☐☐☐☐
Area Code Phone
Email Address (please print clearly)
☐ Home or ☐ Business
_____

6. New York State DMV ID Number
(Driver or Non-Driver ID)
☐☐☐☐☐☐☐☐☐
(Leave this blank if you do not have a New York State DMV ID Number)

7. Name as it appears on degree or other credentials (if different from above) _____

8. Name of supervisor _____ Assigned Number (from Form 4): _____

I practiced Mental Health Counseling as defined below:

"Mental Health Counseling is the evaluation, assessment, amelioration, treatment, modification, or adjustment to a disability, problem, or disorder of behavior, character, development, emotion, personality or relationships by the use of verbal or behavioral methods with individuals, couples, families or groups in private practice, group, or organized settings; and the use of assessment instruments and mental health counseling and psychotherapy to identify, evaluate and treat dysfunctions and disorders for purposes of providing appropriate mental health counseling services."

Duration of supervised experience

Date beginning ____ mo. ____ day ____ yr. Date ending ____ mo. ____ day ____ yr.

Total clock hours practicing Mental Health Counseling _____

9. I request and give my permission to the individual listed in item 8 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure. I also declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution.

_____ _____
Applicant Signature Date

Section II: Certification of Supervised Experience

Instructions to the Supervisor: Complete Section II, sign and date the attestation and send the entire form along with any additional information directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant. If the supervised experience occurred outside of New York State, you must include a copy of your license and an operating certificate or authorization for the entity to provide professional services.**

Name of the applicant _____
(see Section I, item 3)

I am a licensed _____ in _____
Professional title *Jurisdiction*

License number (attach a copy of your license if other than New York State) _____ Date licensed ___ ___ ___
mo. day yr.

I am attesting that I supervised the above named applicant for at least one hour per week or two hours every other week in the practice of mental health counseling (defined below):

"Mental Health Counseling is the evaluation, assessment, amelioration, treatment, modification, or adjustment to a disability, problem, or disorder of behavior, character, development, emotion, personality or relationships by the use of verbal or behavioral methods with individuals, couples, families or groups in private practice, group, or organized settings; and the use of assessment instruments and mental health counseling and psychotherapy to identify, evaluate and treat dysfunctions and disorders for purposes of providing appropriate mental health counseling services."

Dates of experience From ___ ___ ___ To ___ ___ ___ ☐ Present
mo. day yr. mo. day yr.

Total hours practicing Mental Health Counseling _____

Identify the employment setting below and attach the operating certificate, NYSED waiver or certificate of incorporation that authorizes the entity to employ Licensed Mental Health Counselors.

Agency/Practice Name _____

Type of Setting (check one)

- ☐ Private practice owned by supervisor
- ☐ Professional entity (PLLC, PLLP, P.C.) owned by qualified qualified supervisor (attached consent from SED)
- ☐ Sole proprietorship or other entity authorized under law (attach certificate of corporation)
- ☐ Program approved by the New York State Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD),Office of Alcoholism & Substance Abuse Services (OASAS), Office of Children & Family Services (OCFS), Department of Corrections and Community Supervision (DOCCS), Department of Health (DOH), State Office for the Aging, or local social service or mental hygiene district (attach operating certificate)
- ☐ Psychotherapy institute chartered by Board of Regents and authorized to provide psychotherapy to the public (attach copy of Regents Charter)
- ☐ Elementary, middle, high school or college authorized to provide psychotherapy services to students (attach copy of authorization)
- ☐ Not-for-profit or other entity authorized by waiver from the State Education Department to employ licensed professionals and provide services (attach waiver and certificate of incorporation)
- ☐ Other (describe) _____

Agency/Practice address _____

Agency/Practice Phone _____ Fax _____ Email _____

Agency/Practice web site _____

The supervisor must be employed by the same agency as the applicant and have access to all patient files and records; have responsibility for the assessment, evaluation and treatment of each patient diagnosed and treated by the applicant practicing under his/her supervision; and each patient must consent to treatment by the supervised applicant.

_____ _____
Signature of agency representative Date

Attestation

I hereby certify that I have read Appendix A and that I meet the requirements to supervise a LMHC applicant. I hereby declare and affirm that I am knowledgeable about, and qualified to attest to, the applicant's work and the work experience and ability and that the work experience described is true and accurate. I understand that any false or misleading information on this form, or related to verification of this applicant's experience, may be cause for charges of misconduct and/or criminal prosecution.

_____ _____
Supervisor Signature Date

Print Name _____

Address _____

_____

Telephone _____ Fax _____ Email _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Mental Health Counseling Unit, 89 Washington Avenue, Albany, NY 12234-1000.